STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155224	B. WING		01/24/2013
NAME OF I	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIE	K	621 W	COLUMBIA ST	
	BIA HEALTHCARE	CENTER	EVANS	SVILLE, IN 47710	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was f	or the Investigation of	F0000	We request a face to face IDR	lon
	This visit was for the Investigation of Complaint IN00122655.		10000	F315 and F 325The creation a	
	Complaint inoc	J122033.		submission of this Plan of	
	G 1 : DIO	)100655 G 1 1		Correction does not constitute	an
	•	0122655 Substantiated,		admission by this provider of a	any
		ndings related to the		conclusion set forth in the	<u>.</u>
		eited at F315, F325, and		statement of deficiencies, or o any violation of regulation. Thi	
	F514.			provider respectfully requests	
				the 2567 Plan of Correction be	
	Unrelated defication	iency is cited.		considered the Letter of Credi	ble
				Allegation and requests a Pos	t
	Survey dates:			Survey Revisit on or after	
	January 22, 23,	and 24, 2013		February 7,2013	
		,			
	Facility number	·· 000129			
	Provider number				
	AIM number: 1				
	7 HIVI Humber. 1	00200700			
	Survey team:				
	Anne Marie Cra	ays RN			
	Census bed type	e:			
	SNF/NF: 156				
	Total: 156				
	Census payor ty	me.			
	Medicare: 29	. F			
	Medicaid: 108				
	Other: 19				
	Total: 156				
	10181. 130				
	G1 . 7				
	Sample: 5				
	l			[	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000129

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

7YEY11

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION II	DENTIFICATION NUMBER: 155224	A. BUILDING  B. WING	00	COMPLETED 01/24/2013
	PROVIDER OR SUPPLIER	ENTER	621 W	ADDRESS, CITY, STATE, ZIP CODE COLUMBIA ST SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  CONTROL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		reflect state findings e with 410 IAC 16.2.			
		ompleted on January 28,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 2 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155224	B. WIN			01/24/2	013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				COLUMBIA ST		
COLLIMB	BIA HEALTHCARE (	CENTED			VILLE, IN 47710		
COLOIVIB	DIA FIEALTHOANE (	SENTER		EVAINS	1VILLE, IN 477 10		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0155	483.10(b)(4)						
SS=D		ISE; FORMULATE					
	ADVANCE DIREC						
		the right to refuse					
		se to participate in					
	experimental research, and to formulate an						
		as specified in paragraph					
	(8) of this section	•	E01	<i></i>	E455 14	,	02/07/2012
			F01	<b>33</b>	F155 What corrective action(	-,	02/07/2013
		ew and record review, the			will be accomplished for thos		
	facility failed to	ensure advanced			residents found to have been	1	
	directives regard	ing resuscitation status			affected by the deficient practice?		
	were documented	d accurately and			Resident B is a full code and	۱ ا	
		ughout the clinical			this is appropriately reflected in		
		residents reviewed with			the medical record. The MAR,	·	
	*				physician orders and face shee	et	
		ves, in a sample of 5.			appropriately indicate the resid		
	Residents B and	C			code status.		
					·Resident C no longer reside	es	
	Findings include	:			in the facility.		
					How will you identify other		
	1. On 1/22/13 at	10:45 A.M., the			residents having the potentia	ul	
	Administrator pr	ovided a list of residents,			to be affected by the same deficient practice and what		
	*	who were alert, oriented,			corrective action will be take	n2	
	•	e. Resident B was not			·All residents have the poten		
					to be affected by the alleged		
	indicated as bein	g interviewable.			deficient practice.		
					DNS/SSD/designee has audite	ed	
	The paper clinica	al record of Resident B			every resident chart on or befo	re	
	was reviewed on	1/24/13 at 10:30 A.M.			February 7 th , 2013 to ensure		
	An "Adult Resus	scitation Order," dated			advanced directives are		
		, "In the event of Cardiac			accurately reflected on every a	area	
	·				of the chart required including		
	and/or Pulmonar	-			physician orders, yellow sheet		
	Resuscitation"	•			when appropriate, face sheet a the MAR. Any clarifications or	ai iu	
					discrepancies will be reported		
	Physician recerti	fication orders, initially			immediately to the DNS/design	nee	
	dated 10/31/12 a	nd included in the			and family or appropriate party		
					will be notified and correct		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155224				01/24/20	13
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLLIME	BIA HEALTHCARE	CENTED			SVILLE, IN 47710		
		CENTER			· · · · · · · · · · · · · · · · · · ·		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPR		ATE CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG		<u> </u>	DATE
	January 2013 orders, indicated, "DNR"				advanced directives will be documented. Residents and		
	[do not resuscita	ate].			Families will be counseled on		
					advanced directives upon		
	A face sheet in t	the electronic medical			admission, at every care		
	record indicated	Resident B was a full			conference and as		
	code.				SSD/DNS/designee find		
	30.00.				appropriate and any changes		
	On 1/24/13 at 10:30 A.M., during				be reported to SSD/designee		
					follow up review of appropriate		
	interview with LPN # 1 and LPN # 2,				documentation regarding char of code status. What measu	-	
	each nurse indicated if a resident was in				will be put into place or wha		
	distress, they would check the resident's				systemic changes you will	`	
	paper clinical re	cord and/or the MAR			make to ensure that the		
	[medication adn	ninistration record] to			deficient practice does not		
	determine if a re	esident was a DNR. LPN#			recur? Residents and Familie	s	
	1 checked Resid	lent B's MAR at that time.			will be counseled on advance		
		as not included on the			directives upon admission, at		
		and LPN # 2 then			every care conference and as		
					SSD/DNS/designee find	, a dill	
		sident had been at the			appropriate and any changes be reported to SSD/designee		
		, and perhaps the code			follow up review of appropriate		
		e hospital transfer paper.			documentation regarding chair		
	The hospital trai	nsfer paper, dated 1/5/13,			of code status.		
	indicated "Code	Status" and the form was			SDC/DNS/SSD/designee		
	left blank. At th	at same time, the			provided education to nurses		
	downstairs Unit	Manager indicated she			regarding advanced directives		
	would investiga	· ·			and notification of change to start for follow up. IDT will review	220	
	We did in vestiga				resident code status at		
	On 1/24/13 at 14	0:50 A.M., the Medical			re-admission and significant		
					change to ensure all		
		er provided unsigned			documentation is consistent w	/ith	
	1 ^ -	rs, dated "1/5/2013			resident desired code status.		
	_ ~	13." The orders included,			the corrective action(s) will I	oe	
	"Code Status: Fi	ull Code." The Medical			monitored to ensure the		
	Records manage	er indicated she had the			deficient practice will not		
	orders in her off	ice waiting for the			recur? DNS/SSD/designee will utilize Advanced		
	physician to sign	n them. The Medical			Directive/Code Status CQI too		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 4 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155224	B. WING			01/24/2	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Records manag	er indicated there should			weekly x 4weeks and monthly	for	
	have been a pin	k copy of the orders in the			at least 6 months and all new		
	clinical record f	for staff.			admissions will be reviewed by	<sup>y</sup>	
					IDT to ensure proper documentation of advanced		
	On 1/24/13 at 1	1:45 A.M., during			directives. Compliance date:		
		the Administrator, she			February 7 2013		
		· · · · · · · · · · · · · · · · · · ·			,		
		de status was correct in					
	-	nd nursing staff should					
		uter record to determine					
	code status.						
	2. The closed cl	inical record of Resident					
	C was reviewed	l on 1/23/13 at 2:00 P.M.					
	Physician recer	tification orders, initially					
	1 -	nd on the December 2012					
	_	13 orders, indicated, "Full					
	Code."						
	A "State of Indi	ana Out of Hospital Do					
	Not Resuscitate	Declaration and Order,"					
	dated 10/24/12,	indicated the resident's					
		ty and physician signed a					
	DNR declaratio						
	Di in deciaratio	11.					
	On 1/24/12 of 1	1:45 A.M. during					
		1:45 A.M., during					
		the Administrator, she					
		olicy regarding DNR and					
		s had changed last fall, and					
	the staff who re	ceived the DNR					
	declaration show	ald have written an order.					
	2 On 1/24/12 a	t 11:15 A.M. the Social					
		t 11:15 A.M., the Social					
	Services Direct	or provided the current					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 5 of 24

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155224	A. BUILDING 00  B. WING	COMPLETED 01/24/2013			
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION			
	facility policy on "Advanced Directives," revised 1/06. The policy included: "Facility shall determine if the Qualified Resident has completed an Advance Directive indicating his/her wishes concerning cardio-pulmonary resuscitation ('CPR'). If so, a copy of the Advance Directive/consent shall be maintained in the resident's medical recordFacility shall then make the appropriate chart entriesindicating to staff that resident is 'DNR' or 'No Code'"  3.1-38(f)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 6 of 24

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CO  A. BUILDING  B. WING	00 	COMPI			
	PROVIDER OR SUPPLIE BIA HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155224	B. WIN		<del></del>	01/24/	2013
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				COLUMBIA ST		
COLUMB	BIA HEALTHCARE (	CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A83.25(d) NO CATHETER, BLADDER Based on the resi assessment, the resident who ente indwelling cathete the resident's clin that catheterization resident who is in receives appropri to prevent urinary restore as much re possible.  Based on observer record review, the a foley catheter of was kept off of the resident requiring tract infection, for reviewed with for of 5. Resident A  Findings include  1. On 1/22/13 at was observed lyit A foley catheter	PREVENT UTI, RESTORE  Ident's comprehensive facility must ensure that a sers the facility without an er is not catheterized unless ical condition demonstrates on was necessary; and a continent of bladder ate treatment and services at tract infections and to normal bladder function as  ation, interview, and the facility failed to ensure drainage bag and tubing the floor, resulting in the gantibiotics for a urinary or 1 of 1 residents bley catheters, in a sample	F03	TAG	We request a face to face IDRF315 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident A has been placed a low bed that is not lowered completely to the floor therefor allowing appropriate space for catheter bag to hang properly without touching the floor.  Catheter care is given per policy  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked. All residents with a catheter	d in re the	
	observed sitting catheter bag, out was observed lyi	25 P.M., Resident A was up in bed, eating. A foley side of the blue cover, ng on the floor. The side			have the potential to be affected by the alleged deficient practic DNS/SSD/designee have assesed every resident with a catheter on or before February th, 2013 to ensure compliance with catheter care and that characters are sufficient to the compliance of the catheter care and that characters are sufficient to the catheter care and that characters are sufficient to the catheter care and that characters are sufficient to the catheter care and that characters are sufficient to the catheter care and that characters are sufficient to the catheter care and that characters are sufficient to the catheter care and the catheter care are sufficient to the catheter care and catheter care care catheter care care catheter care care care care care care care ca	e. 7	
	of the bag with the	he outlet valve was on the			and beds frequently used have	ڊ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 8 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
		155224	A. BUILDING B. WING  01/24/2013		<sub>13</sub>		
			B. WIN		ADDRESS OVEN STATE OF CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	floor. The blue o	cover was hanging on the			designated and appropriate		
	bed frame.				places to hang catheter bags t		
	oca mamo.				will enable bags to hang witho		
	0: 1/22/12 -4 0:	20 A.M. D: 1 A			touching the floor and that bag	ıs	
		30 A.M., Resident A was			are covered appropriately.		
	1	n a low bed, asleep. A			DNS/SDC/designee have	_	
	foley catheter ba	ng in a blue protective			educated staff by February 7 t		
	cover was hangi	ng on the bed frame,			on proper placement of cathet bags and catheter care policy.		
	lying on the floo	_			Nurses have had additional		
					education on preventing infect	ion	
	The climical mass	and of Docidant A was			as it relates to catheter care.		
	The clinical record of Resident A was				What measures will be put in	to	
	reviewed on 1/23/13 at 8:45 A.M.				place or what systemic		
	Diagnoses inclu	ded, but were not limited			changes you will make to		
	to, kidney diseas	se, dementia, and urinary			ensure that the deficient		
	retention.				practice does not recur?		
					DNS/SSD/designee have		
	Dhygiaian ardara	s, initially dated 9/10/12			assessed every resident with a		
	_	-			catheter on or before February		
		ary 2013 recertification			th , 2013 to ensure compliance		
		l, "Foley Catheter care			with catheter care and that cha		
	every shift," and	l "16 Fr [French foley			and beds frequently used have	=	
	catheter] to BSD	[bedside drainage] Dx			designated and appropriate places to hang catheter bags t	hot	
	[diagnosis] Neur	rogenic Bladder."			will enable bags to hang witho		
	[8]				touching the floor and that bag		
	A Minimum Da	to Cat [MDC] aggaggment			are covered appropriately.	,	
		ta Set [MDS] assessment,			DNS/SDC/designee have		
	· ·	ndicated the resident			educated staff by February 7 t	h	
	scored a 4 out of	f 15 for cognitive status,			on proper placement of cathet	er	
	with 15 indicating	ng no memory			bags and catheter care policy.		
	impairment. The	e MDS assessment			Nurses have had additional		
	_	ident required extensive			education on preventing infect	ion	
		o + staff for bed mobility,			as it relates to catheter care.		
		•			DNS/nurse managers/designe	e	
		s totally dependent on two			will conduct rounds to ensure foley catheter drainage bag ar	nd	
	+ staff for toilet	use.			tubing is kept off of floor daily		
					all shifts. How the corrective	J. 1	
	A Care Plan, dat	ted 9/20/12, indicated:			action(s) will be monitored to	,	
	"Problem, Resid	ent requires an			ensure the deficient practice		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 9 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155224	A. BUI. B. WIN			01/24/	/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indwelling urina	ry catheter R/T [related			will not recur?		
	to]: urinary reter	ntion and neurogenic			DNS/SSD/designee will visual	ly	
	bladderApproa	achDo not allow tubing			monitor all catheter bags to	orly	
		e drainage system to			ensure bags are covered prop and not touching the floor daily	-	
		Store collection bag			14 days, weekly x 6 weeks an		
		ve dignity pouch."			monthly for at least 6 months.		
	miside a protectiv	ve arginty poucii.			DNS/SDC/designee will utilize		
	On 1/22/12 -/ 1	20 D.M. duning intermi			Catheter assessment CQI tool		
	On 1/23/13 at 1:20 P.M., during interview with the Administrator, she indicated the				monthly for at least 6 months.		
					nursing staff will continue to be educated during this time for	е	
	foley catheter bag should not be placed on				constant monitoring of the		
	the floor.				appropriate catheter care		
					practices. · Any need for		
	On 1/24/13 at 10	0:55 A.M., during			additional training will be repo	rted	
	interview with th	ne interim Director of			to ED.		
	Nursing, she ind	icated she had just			·All audit tools will be brough before the CQI committee	nt	
	received an orde	er for an antibiotic for			monthly		
		to a UTI [urinary tract			·Any non-compliant issues n	nav	
	infection].				be addressed with re-education		
	micetionj.				and/or disciplinary action.		
	The clinical reco	ord of Resident A was			Compliance date: February 7	•	
		on 1/24/13 at 2:30 P.M. A			2013		
	1 * *	r, dated 1/24/13 at 10:50					
		"Cipro [antibiotic]for					
		to] cloudy, foul smelling					
	urine [and] mala	ise."					
	2. On 1/24/13 at	2:20 P.M. the					
		· ·					
		rovided the current					
		n "Indwelling Urinary					
	-	wed 12/2012. The policy					
		ce drainage bag below					
	level of bladder.	Do not place bag on side					
	rail or on bed'	' The policy did not					
	include specifica	ally not placing the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 10 of 24

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155224			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/24/2013
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
COLUME	BIA HEALTHCARE	CENTER		COLUMBIA ST VILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	drainage bag on	the floor.			
	This federal tag IN00122655.	relates to Complaint			
	3.1-41(a)(1) 3.1-41(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 11 of 24

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM 01/2	TE SURVEY  IPLETED  24/2013		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST					
	BIA HEALTHCARE	CENTER STATEMENT OF DEFICIENCIES		VILLE, IN 47710		(VE)		
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 12 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155224		A. BUILDING 00		(X3) DATE SURVEY COMPLETED 01/24/2013	
	ROVIDER OR SUPPLIEF		621 W COLUMBIA ST EVANSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0325 SS=G	483.25(i) MAINTAIN NUTF UNAVOIDABLE Based on a resid assessment, the resident - (1) Maintains acc nutritional status, protein levels, un condition demons possible; and (2) Receives a th a nutritional prob  Based on observ record review, th accurate weights recorded, thereb interventions to of 3 residents re a sample of 5. R  Findings include  1. On 1/22/13 at initial tour, the in Nursing [DNS] a Manager indicate experienced a w 2 months.  On 1/22/13 at 2:	ent's comprehensive facility must ensure that a septable parameters of such as body weight and less the resident's clinical strates that this is not erapeutic diet when there is lem.  ation, interview, and he facility failed to ensure a were obtained and y failing to provided prevent weight loss, for 2 viewed for weight loss, in esident A, Resident C	F0325	We request a face to face IDRF325 What corrective action(s) will be accomplishe for those residents found to have been affected by the deficient practice?  Resident A was placed on weekly weights in January. Additional care plan measures were also in place plan me	per ent ent es ed d

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 13 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		COMPL	COMPLETED	
		155224				01/24/	2013
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
001111141	COLUMBIA LIEALTHOADE CENTED				COLUMBIA ST		
COLUM	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	a piece of pizza	left from lunch.			assessed every resident with		
					weight loss and RD		
	The clinical rec	ord of Resident A was			recommendations have been		
					implemented. RD and		
		23/13 at 8:45 A.M. The			DNS/designee with IDT meet		
		mitted to the facility on			weekly for NAR (Nutritionally a	at	
	9/9/12 with dia	gnoses including, but not			Risk) to update care plans as necessary for at risk residents		
	limited to, dem	entia and diabetes			DNS/SDC/designee have	•	
	mellitus.				educated staff by February 7 t	·h	
					on proper meal consumption		
	Dhysiaian ardar	rs, dated 9/9/12, indicated			policies and consistent weight		
	1 -				procedures. DNS/ED/RSM h		
		s on a CCHO [concentrated			educated therapy staff to		
	carbohydrate] c	liet.			encourage continued		
					communication with		
	An admission N	Minimum Data [MDS]			Nursing/Dietary departments	_	
		ed 9/16/12, indicated the			regarding nutrition concerns o	f	
	1	a 3 out of 15 for cognitive			residents to enhance optimal		
		•			functional ability. What		
	1	indicating no memory			measures will be put into pla		
	_	e MDS assessment			or what systemic changes yo will make to ensure that the	ou	
	indicated the re	sident required limited			deficient practice does not		
	assistance of or	ne person for eating, and			recur? DNS/RD/designee hav	/Δ	
	his weight was	165 lbs.			assessed every resident with		
					weight loss and RD		
	A Care Plan de	ated 9/17/12 and			recommendations have been		
					implemented. RD and		
		n 1/22/13, indicated:			DNS/designee with IDT meet		
	•	dent requires a therapeutic			weekly for NAR (Nutritionally a	at	
		lx [diagnosis] of DM			Risk) to update care plans as		
	[diabetes mellit	tus]. Goal, Resident will			necessary for at risk residents		
	not display sign	nificant weight loss			DNS/SDC/designee have	.L	
	1	view. Approach, meal is			educated staff by February 7 to on proper meal consumption	n	
	"	, Provide diet per MD			on proper meal consumption policies and consistent weight		
	1	*			procedures. DNS/ED/RSM h		
	order, Keview I	abs as available."			educated therapy staff to	40	
			- [		encourage continued		
	Speech therapy	treatment notes included			communication with		
	the following n	otations:			Nursing/Dietary departments		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 14 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET		TED		
		155224	B. WIN			01/24/2	2013
			P. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		l	COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES			ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sweets for nutritic consuming any of Unbalanced means leads to poweakness, and unwhen appropriate improve"  12/3/12: "Pt combalance [sic] die meals aren't' ev snack on candy at throughout the drather than eat with dietarySLP [spathologist] appropriate concerning drug. After discripted possible According to the his residency in he has gained 6.  12/4/12: "Continute the swallow when his mealsPt has not consumer the sw	tinues to eat a very poorly it, at this point. Most yen consumed. He tends to and dessert off and on lay when he is hungry what is offered by beech language roached the 1st shift g an appetite enhancing ussion, therapist sible wt. [weight] loss. to past 2 1/2 to 3 months of current nursing facility, lbs not lost"  The to brain storm with concerning swallow, betivation to improve hisIt is difficult to treat his to be barely eats his ot lost wt in past couple of opetite enhancing drug			regarding nutrition concerns of residents to enhance optimal functional ability. Speech Therapy staff will also attend I meeting on a regular basis. He the corrective action(s) will to monitored to ensure the deficient practice will not recur? DNS/RD/designee will monitor weights per policy and implement needed changes a resident condition dictates. DNS/RD/IDT/designee will meekly for NAR and provide findings to CQI committee monthly. All scheduled weight will be monitored by RD/DNS/during weekly Nar meeting an re-weights will be performed a indicated. RD recommendatio will be given when appropriate and DNS/RD/designee will us CQI tool to monitor interventions and programs utilizing CQI tool weekly x 4 at monthly for at least 6 months report findings to CQI committ monthly. Compliance date: February 7 2013	NAR ow De  d s eet s IIDT d as ns e e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 15 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVE	EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155224	B. WIN	G		01/24/2013	
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
COLUME	BIA HEALTHCARE	CENTER			COLUMBIA ST VILLE, IN 47710		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COM	IPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	Г	DATE
		ess note, dated 12/6/12 at					
		ated, "Resident on					
		hydrate diet per order. On					
	_ ~	consumed 50% B					
	-	%L [lunch]/100%D					
		s recorded in the					
		cord over the last 7					
	, , ,	62 lbs (11/12)No new					
	recommendation	ns at this time."					
		y note, dated 12/7/12,					
	indicated: "He	admits he has a poor					
	appetite for bldg	[building] food and likes					
	to eat snacks/car	ndy instead. There have					
	been days when	he has been observed					
	eating 60-75% o	of his meal in the past two					
	weeks"						
	Nursing progres	s notes, dated 12/8/12 at					
	2:28 A.M., indic	cated, "Alert and					
	oriented with pe	riods of confusion at					
	timesEats mea	ls in his room per his					
	request and feed	s self"					
	Nursing progres	s notes, dated 12/17/12 at					
		cated, "Feeds self with					
	tray set up"	3045 5011 WIMI					
	au, see up						
	Nursing progres	s notes, dated 1/1/13,					
		eds self with set up eats in					
	room per reques	t"					
	A dietary progre	ess note, dated 1/13/13,					
		ary wt [weight] 132 #					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 16 of 24

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		155224	B. WIN			01/24/2013	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	KOVIDER OR SUPPLIER			621 W (	COLUMBIA ST		
COLUMBIA HEALTHCARE CENTER			EVANS	VILLE, IN 47710			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>		TAG	Dirichi.(C.)		DATE
		wn 19% x 30 days. Meal					
		Spoke with nursing who					
		dent] refusing to eat at					
		ally consumes 51-100%					
		nmend change diet to					
	-	Remeron [appetite					
	stimulant] daily.	Will add to weekly wts."					
	A Care Plan, dat	ted 1/22/13, indicated,					
		ent has experienced					
	· ·	ht loss x 30 days. Goal,					
	"	t experience further					
	significant weig	*					
	On 1/23/13 at 10	0:00 A.M., during					
		he Registered Dietician					
	[RD], Administr	_					
		Administrator indicated					
	· ·	ed a problem with the					
	1 -	The RD indicated she					
		ility on 12/17/12, and					
		y weights were obtained,					
		the Administrator the					
		I to have more residents					
	, , , ,	than they had ever had					
	_	Administrator indicated					
	1 -	tem for weights were for					
		e to obtain the monthly					
		n would give them to the					
		o be entered into the					
	l -	Administrator indicated					
		f the previous DON was					
		rect weights, in order to					
	_	t loss. The Administrator					
	I	t 1000. The Auministrator	I				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 17 of 24

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	(X2) MULTII A. BUILDING B. WING		00	(X3) DATE S COMPL <b>01/24</b> /	ETED
	PROVIDER OR SUPPLIER		ST 62	1 W C	DDRESS, CITY, STATE, ZIP CODE COLUMBIA ST /ILLE, IN 47710	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated she did had lost 30 lbs in had a gradual we indicated it was a first been weight but that would had difference. The Anew system for reweights was now 2. On 1/22/13 at interview with a Resident C, she is surprised to know so much weight indicated she vis approximately even mother was usual did not notice the The closed clinic was reviewed on Diagnoses included, dementia, nor diabetes mellitus and Parkinson's of Physician orders and on the Janual orders, indicated liquids." An additional process of the closed clinic was reviewed on Diagnoses included the closed clinic was reviewed on Diagnoses includ	I not think Resident A I I month, but maybe had sight loss. The RD unclear if the resident had ed with his prosthesis on, ave been only a 6 lb Administrator indicated a ecording and entering in place.  10:25 A.M., during family member of indicated she was very w that her mother had lost since last fall. She ited her mother very 2 weeks, but that her lly covered up, and she e weight loss.  cal record of Resident C 1/24/13 at 2:00 P.M. ded, but were not limited n-insulin dependent c, congestive heart failure,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 18 of 24

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155224	B. WIN	G		01/24/2013	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					COLUMBIA ST		
COLUME	BIA HEALTHCARE (	CENTER		EVANS'	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		ent, dated 9/25/12,					
		ident was unable to					
	-	or cognitive status,					
	•	ve assistance of 1 staff for					
	eating, and weig	hed 145 lbs.					
	,	1 . 1 10/5/55					
		ent, dated 12/5/12,					
		ident was unable to					
	_	or cognitive status,					
	•	ve assist of 1 staff for					
	eating, and weig	hed 140 lbs.					
		lated 12/6/12 at 1:52					
		"Resident is on a					
	_	thin liquids per order.					
	On average resid	lent consumed 75% B/					
	63% L/ 50% D;	weight 140 lbs					
	(11/12)Recent	abnormal pertinent lab					
	values as of 12/4	Recommend double					
	protein at breakf	ast r/t [related to] low					
	albumin level an	d best intake being at					
	breakfast meal."	•					
	A Care Plan rega	arding weight loss was					
	not located in the	e clinical record.					
	The resident was	s transferred to the					
	hospital on 1/7/1	3 at 5:00 P.M. due to					
	lethargy.						
	On 1/23/13 at 2::	30 P.M., the					
	Administrator pr	ovided a weight report					
	for Resident C, v	which indicated the					
	resident's weight	t on 11/12/12 was 140					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet Page 19 of 24

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	A. BUII	DING	NSTRUCTION 00	(X3) DATE : COMPL 01/24/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
COLUME	BIA HEALTHCARE (	CENTER		EVANS	VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETION DATE
	lbs, and on 12/11 Administrator in January weight, been discharged weights weren't of the 11th of the m On 1/24/13 at 9: hospital records resident's weight lbs on 1/7/13 at 5 had lost 22 lbs si On 1/24/13 at 12 Administrator pr record for Januar Administrator in from the restorat indicated Reside lbs. The Administ not know the dat it was not record being transferred 1/7/13. The Adm could not explain difference, but the utilized a difference	/12 was 142 lbs. The dicated there was no because the resident had on January 7, and the due to be completed until bonth.  15 A.M., admission were reviewed. The was documented as 120 5:29 P.M. The resident nice 12/11/12.  100 P.M., the ovided a written weight ry, undated. The dicated the record was live aide. The record nt C's weight was 136 strator indicated she did e of the weight, but that ed due to the resident to the hospital on a tinistrator indicated she in the 16 lb weight at perhaps the hospital int scale. The			CRUSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NE .	
	using a different recording the res						
	•	1:20 P.M., the ovided the current "Resident Weights,"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 20 of 24

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155224	A. BUILDING  B. WING	00	COMPI 01/24	LETED
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	621 W	ADDRESS, CITY, STATE, ZIP CO COLUMBIA ST SVILLE, IN 47710	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	dated 3/10. The policy included: "A monthly weight log is sent to the following individuals by the [blank] day of the month: Director of Nursing, Registered Dietician, Dietary Services Manager, MDS Coordinator"  This federal tag relates to Complaint IN00122655.  3.1-46(a)(1)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 21 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155224				01/24/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
COLLIMB		CENTED			COLUMBIA ST		
COLUMBIA HEALTHCARE CENTER			EVANS	VILLE, IN 47710			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
	RECORDS-COM	PLETE/ACCURATE/ACCE					
	SSIBLE						
	•	maintain clinical records on					
		accordance with accepted					
		dards and practices that					
	•	curately documented;					
	organized.	e; and systematically					
	organizeu.						
	The clinical record	d must contain sufficient					
		ntify the resident; a record					
		assessments; the plan of					
		s provided; the results of					
	any preadmission	screening conducted by					
	the State; and pro	ogress notes.					
			F05	14	F514 What corrective action(	s)	02/07/2013
					will be accomplished for thos	se	
					residents found to have beer	1	
					affected by the deficient		
	D 1 '	1 1 1 1			practice?		
		ew and record review, the			·Resident A documentation I		
	facility failed to	ensure documentation			been reviewed to ensure prop		
	regarding the fre	quency of bowel			bowel movement documentati	on	
	movements was	accurate, for 1 of 4			has occurred.		
	residents reviewe	ed for documentation, in			How will you identify other		
	a sample of 5. Re	· · · · · · · · · · · · · · · · · · ·			residents having the potentia	11	
	a sample of 3. Ro	esident A			to be affected by the same		
					deficient practice and what corrective action will be take	<b>"</b> 2	
	Findings include				·All residents have the poter		
					to be affected by the alleged	iuai	
	1. The clinical re	ecord of Resident A was			deficient practice.		
	reviewed on 1/23	3/13 at 8:45 A.M.			·DNS/SDC/designee have		
					provided education by Februa	ry 7	
	An alastronia "V	itals Report" dated			th to all nursing staff regarding		
		•			documentation requirements		
		3, indicated the resident			related to bowel management.		
		vement on 1/1, 1/2, 1/7,			·All charts have been audite	d	
	1/8, 1/20, 1/21, 1	/22, and 1/23.			through bowel management		
	ŕ		1		report to ensure proper		ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11 Facility ID: 000129 If continuation sheet Page 22 of 24

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  01/24/2013
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE 621 W COLUMBIA ST EVANSVILLE, IN 47710	ZIP CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION THE APPROPRIATE
	On 1/23/13 at 9:50 A.M., during interview with the 2nd floor Unit Manager, he indicated bowel movements were recorded each shift on the Vitals Report. He indicated a report was printed out daily which indicated which residents had not had bowel movements for 3 days, and this report was reviewed by the nursing staff. He indicated there was no other location he could think of which recorded bowel movements.  On 1/23/13 at 1:20 P.M., during interview with the Administrator, she indicated staff should be documenting bowel movements every shift on the Vital Signs page. She indicated the Minimum Data Set coordinator had indicated there was another location in which CNAs may be documenting bowel movements. The Administrator indicated it was not the right location, and staff would have to be reinserviced.  2. On 1/23/13 at 1:20 P.M., the Administrator provided the current facility policy on "Bowel Elimination," dated 6/2012. The policy included: "Bowel movements will be recorded on the facility EMR [electronic medical record] and/or record daily by the direct care staff. The DNS [Director of Nursing Services]/designee will assign a charge	documentaton DNS/SDC/design management report to ensure proper of Any missing docu promptly brought for clarification/ed possible disciplina warranted. What be put into place systemic change make to ensure to deficient practice recur?  DNS/SDC/design management report to ensure proper of Any missing docu promptly brought for clarification/ed possible disciplina warranted. How to action(s) will be re ensure proper of Any missing docu promptly brought for clarification/ed possible disciplina warranted. How to action(s) will be re ensure proper of Any missing docu promptly brought for clarification/ed possible disciplina warranted. CQI to by DNS/designee monthly for at leaf Any need for addi will be reported to	ort 5x per week documentation. mentation is to assigned staff ucation and ary action when measures will or what is you will hat the does not  ignee have in by February 7 aff regarding quirements hanagement. ee review bowel ort 5x per week documentation. mentation is to assigned staff ucation and ary action when the corrective monitored to ent practice  ee review bowel ort 5x per week documentation. mentation is to assigned staff ucation and ary action when the corrective monitored to ent practice  ee review bowel ort 5x per week documentation. mentation is to assigned staff ucation and ary action when ol will be used weekly x4 then st 6 months tional training

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

	of correction (155224) To Deficiencies (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/24/2013
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	621 W	ADDRESS, CITY, STATE, ZIP CODE COLUMBIA ST VILLE, IN 47710	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	nurse on a specific shift to review all BM Records on a daily basis"  This federal tag relates to Complaint IN00122655.  3.1-50(a)(1) 3.1-50 (a)(2)	TAG	·All audit tools will be broug before the CQI committee monthly ·Any non-compliant issues is be addressed with re-education and/or disciplinary action.  Compliance date: February 12013	may on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7YEY11

Facility ID: 000129

If continuation sheet

Page 24 of 24